MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

Thursday, November 15, 2012

10:00 a.m.

Room 643, LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, November 15, 2012 in Room 643, LOB at 10:00 a.m. Representatives Avila, Boles, Collins, Current, Hollo, Randleman, Steen, and Torbett were present. Representative Torbett presided.

Representative Torbett asked for approval of minutes. Representative Current made the motion and Representative Boles seconded. The minutes were approved unanimously.

Christopher B. Taylor, CPA, Assistant Secretary, North Carolina Medical Care Commission, K.D. (Kip) Sturgis, Assistant Attorney General, North Carolina Department of Justice, and David Motsinger, CPA, Partner, Dixon Hughes Goodman LLP presented the Certificate of Public Advantage Audit (see attached and on committee website). There were questions from Representatives Avila and Collins regarding market share.

Jan Paul, Staff Council presented Update on Recent Court of Appeals Decision in Novant Health v. NC DHHS (see attached and on committee website). There were questions from Representatives Avila, Collins, Current, and Torbett regarding specific harm, AC3 explanation, State Health Medical Facilities Plan, and exemptions for AC3. There were questions from Representatives Avila, Collins, Current and Torbett regarding specific harm, explanation from AC3s when they want to expand, exemption for AC3.

Representative Torbett went over the previous recommendations by the committee (see attached and on committee website). 1. Services Regulated-approved unanimously. 2. Thresholds (Draft Legislation "Adjust CON Monetary Thresholds"(see attached and on committee website))-approved unanimously. 3. Changes to Previously Issued CONS-approved unanimously. 4. SHCC- approved unanimously. 5. SMFP-Craig Smith, CON-the policy AC3 exemption only applies to the Main Campus of the institution. The new policy provides for more involvement of the folks in the community in the process. Todd Hemphill, Bode, Call and Stroupe, LLC- copy of changed AC3 policy says to require an applicant who was a policy AC3 to actually go to the other providers in the community and discuss the issues. Catherine Cummer, Duke University Health System-A few other changes are limitations on the use of the policy, the policy can be used when an academic medical center teaching hospital and show that it needs the expansion of the assets for research, the recruitment of faculty, or the expansion of students or residents. One thing that the policy now says is that if you are using the policy justification of recruiting additional faculty, that really only applies for acquisition of equipment, not for beds and operating rooms, so that has narrowed the scope of the policy. Another thing the new policy does is to make more explicit the documentary evidence needed to show why this particular project is needed for the academic purpose. Finally, the policy, for the first time imposes post implementation of reporting requirement about how you are actually using the policy AC3 assets you've developed for the academic purposes that you sited in the application. I would say it has both increased the collaboration, narrowed the use of it, and really provided some increased rigor for the CON section to evaluate. Noah

Huffstetler, Nelson Mullins- I was council for Novant Health in the recent case that was decided by the court of appeals and I would agree generally with the statements made that this policy has been tightened up some, at least for this year. The plan is adopted on a yearly basis by the SHCC and can be changed at any time. One of the considerations that has arisen earlier in this committees deliberations is the possibility of codifying this language so that it is established once and for all and not subject to change. In response to Representative Current's question, what is required to show the need for a policy AC3 application is simply a letter from a dean of an associated medical school that says we would like to have this for teaching purposes and that was all that was required at the time of this. To answer Representative Avila's question, the troublesome thing about the court of appeals decision is that Novant put in evidence that it would lose between 10 and 20 million dollars in net revenue a year as a result of 8 new operating rooms in the county, where there was already 7 too many. The court basically said that sort of harm is not sufficient to show substantial prejudice. So in practical effect, what it means is the only party that can challenge one of these cases is a disappointed applicant who had an application competing with the AC3 project. The problem there is that, to address Representative Collins question, what policy AC3 does is allow an academic medical center to apply for when no other medical center is able to do so. In the future, for example, in Forsyth County, Baptist Hospital will always be able to apply, Novant cannot apply under that same policy, nor can it challenge the approval of one of these applications, because it doesn't have a completing application, and therein lays the rub. The court says if you have problems with the fairness of this policy, they must be addressed by the legislature, not the courts. Catherine Cummer, Duke University Health System, one of the other changes in last year's modification policy talks about how AC3 assets are going to be dealt with and the methodology need determinations, at least going forward. Representative Steen asked of Noah Huffstetler, Nelson Mullins, the court said that they recognized there was a competitive advantage, but this would have to be settled by the general assembly, is this true for the 2012 policy? Noah Huffstetler, Nelson Mullins, the question of whether or not you could appeal is not affected by any of the changes, that problem still remains. What the court appeared to be saying, is that no matter how severe the monetary impact is on a provider, that alone, is not sufficient to give them standing to appeal and that again is the problem with AC3, because what AC3 allows an academic medical center to do, is to apply in an area in which there is no need and so it will always be a noncompetitive application. What the court seemed to be saying here is that in this situation, just because you are a business competitor of that entity and suffer monetary damages, that are not sufficient to give you a right to appeal and that is not effected by the changes in the policy. Todd Hemphill, Bode, Call, and Stroupe, LLP, I would like to respond to a comment Mr. Huffstetler made, the administrative law judge and agency rejected that and essentially found that Novant would not lose any money and that they did not prove their case. Noah Huffstetler, Nelson Mullins, I would respectfully disagree with my colleague's comments. The approval was made to study and review the new AC3 policy and DHSR would report to HHS oversight. 6. Appeals Process (attached and on committee website draft legislation)-unanimous approval. 7. Related Hospital Issues-unanimous approval. Joe Lanier, Nelson Mullins, on behalf of Caromont Health, which does support recommendation. Our concern is that a public hospital authority, which is a little bit different than a nonprofit hospital, its boundary extends from the county from which it is formed out 10 miles in that county. Outside of that is not considered to be the hospital authority boundary and in order for it to perform services, as sort of a quasi-government unit, it has to obtain the cooperation of a hospital within that county or if no hospital exists, the healthcare agency within that county. Our objection to this is that, as a quasi-governmental entity, allowing them to follow those rules outside the border of the county in its extraterritorial jurisdiction area, does not allow the hospital authority the ability to cooperate fully with the hospital that is already in the county. What we are arguing is that the quasi-local government authority needs to cooperate with the hospital in the neighboring county in order to provide the kind of collaboration between healthcare units that we would like to see. The

other point that we would to make is that a hospital authority as created under 131.E has special powers that non hospital authorities have, including the power of eminent domain, the power of county appropriations that are usually subsidized and it is of concern to us that that type of hospital authority has unfair market advantages. Sandy Sands, Nexsen Pruet, representing Carolinas Health Care, which is one of 3 hospital authorities in this state. The hospital authority act was created in 1943 and the primary reason was so that the hospital in Charlotte, Charlotte Memorial Hospital, which was the charity hospital down there could go forward. This hospital authority can do what it needs to and within 10 miles. There was a fuss down there over the last several years and it appears to me that the hospital in Gaston County is now trying to have the legislature put in an unfair competitive advantage over Carolinas Health Care. We would just like to have a level playing field. 8. COPA-Recommendation of a formation committee to direct COPA business study. Representative Avila suggested COPA is a bigger issue than to make specific recommendations and a committee that can focus on COPA is put in place. Representative Boles suggested that since he is not hearing there is a problem from Drexdal Pratt's office and is comfortable with the report. Lanier Cansler, former member of this body, reported he was very involved in passing the COPA legislation. The reason is a state wide legislation that any hospital can choose to go under; it was passed in order to assist in Buncombe County. The reason for the COPA was to be able to demonstrate there was an advantage to the community of this going together because without it they had to go through a lot of things with anti-trust, etc. to make it happen. The COPA has done exactly what it was meant to do and the Mission Health System has done exactly what they were required to do under the COPA. I would suggest that COPA not be the discussion. If you are concerned about the way our healthcare system is evolving, then have that discussion. Denise Gunter , Western North Carolina Community Healthcare Initiative, reports that COPA is the issue. We need to do a deeper dive. In the Vistnes report problems were found such as regulatory evasion and incentive problems, Mission's expansion, expansion into lower margin service areas, contracting, and what competitors and citizens in the area had to say about unfair competition. Rowena Buffett Timms, Senior Vice President at Mission Health for Government and Community Relations, reports that the COPA was enacted because of an anti-trust monopolistic concern that there might have been at that time. We are below our peer study group at each index which indicates that the public is not being taken advantage of. We don't force, and we couldn't obviously, patients to come to Mission. Our member hospitals are looked at frequently as we're asked to bid on the RFP process. Representative Torbett suggested that if the interested parties cannot work out the problems between themselves by the end of next session then the study committee would be suggested. Representative Boles voted against the recommendation.

Representative Avila presented a copy of a draft bill that she was not prepared to discuss at today's meeting, however, would be at the next meeting (see attached and on committee website).

Representative Torbett adjourned the meeting at 3:00pm.

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Representative John Torbett, Co-Chair Presiding Viddia Torbett, Clerk

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Representative Fred Steen, Co-Chair